

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2013
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NAME OF PROVIDER OR SUPPLIER
ASBURY PLACE AT JOHNSON CITY

STREET ADDRESS, CITY, STATE, ZIP CODE
**105 WEST MYRTLE AVENUE
 JOHNSON CITY, TN 37604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>During the Life Safety portion of the annual Licensure survey conducted on December 3, 2013, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</p>	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Debra W. Hildner

Executive Director

12/17/13

STATE FORM

0809

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If continuation sheet 1 of 1